

RECEIVED

PRINTED: 10/23/2007  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 TEWKESBURY PL, NW WASHINGTON, DC 20012</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1000	<b>INITIAL COMMENTS</b>  A licensure survey was conducted from October 9, 2007 through October 10, 2007. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home, interviews with residents, residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	1000		
1090	<b>3504.1 HOUSEKEEPING</b>  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas:  The finding includes:  The governing body failed to ensure the maintenance of the facility's environment, as evidenced by:  a. Inspection on October 10, 2007 revealed an unstable driveway gate which was attached to fencing that has jagged edges;  b. Inspection of the kitchen revealed a broken oven door handle.	1090	<b>3504.1</b>  a. The driveway gate and fencing will be repaired or replaced by... 11-15-07. b. The oven door handle will be replaced by... 11-1-07.  The facility manager conducts routine weekly environmental inspections to identify such issues and report them for timely repair... 11-1-07.	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6889

8ZZD11

TITLE

(X6) DATE

10-31-07

If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 TEWKESBURY PL, NW WASHINGTON, DC 20012</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file.</p> <p>The finding includes:</p> <p>Review of personnel records on October 9, 2007 at approximately 7:25 PM revealed no documented evidence of current health certificates for the Psychologist and Physical Therapist consultants. In an interview with the House Manager on October 10, 2007 at approximately 1:10PM it was acknowledged that the health certifications were not available during the survey.</p>	I 206		
I 227	<p><b>3510.5(d) STAFF TRAINING</b></p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of six</p>	I 227	<p>3509.6</p> <p>MTS tracks personnel file information and routinely informs staff and clinical professionals when items need to be updated. Both the PT and Psychologist have been notified about their health certificates and will submit updated health certificates by... 11-1-07.</p>	

Health Regulation Administration  
STATE FORM

6899

8ZZD11

If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/10/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 TEWKESBURY PL, NW WASHINGTON, DC 20012</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 227	Continued From page 2  clients in the facility. (Clients #1, #2, #3, #4, #5 and # 6 )  The finding includes:  Interview with the Qualified Mental Retardation Professional (QMRP) on October 9, 2007 at approximately 6:50 PM revealed that all nursing staff were trained in CPR. Record review on October 9, 2007 at approximately 6:52 PM revealed that two out of four nursing staff did not have current CPR certifications. There was no documented evidence that all nursing staff had CPR training and current CPR certifications.	I 227			
I 379	<b>3519.10 EMERGENCIES</b>  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.  This Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure that the Department of Health (DOH) was notified of any unusual incident which substantially interferes with a resident's health for one of three residents in the sample. (Resident #3)  The findings include:	I 379	3510.5 (d)  MTS will insure that the two nurses cited are CPR certified by...11-30-07. And will add this consideration to its personnel training format...11-1-07.		

Health Regulation Administration  
STATE FORM

6899

8ZZD11

If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/10/2007
NAME OF PROVIDER OR SUPPLIER  M T S		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 TEWKESBURY PL, NW WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1379	Continued From page 3  1. Review of an incident report dated May 16, 2007 on October 9, 2007 at approximately 1:30PM indicated that Resident #3 was taken to an emergency room by the group home staff after complaining of a swollen left ankle at his day program. Review of the emergency room discharge summary dated May 16, 2007 on October 9, 2007 at approximately 1:35PM revealed that Resident #3 had sustained a closed fracture of the left ankle. Interview with the House Manager on October 9, 2007 at approximately 1:40PM revealed that this unusual incident was forwarded to the DOH. The DOH received notification of this incident on May 21, 2007, three business days later.  2. Review of an incident report dated June 14, 2007 on October 9, 2007 at approximately 1:40PM indicated that Resident #3 was taken to an emergency room by ambulance after complaining of chest pain at his day program. Review of the hospital discharge summary dated June 18, 2007 on October 9, 2007 at approximately 1:45PM revealed that Resident #3 was diagnosed with severe constipation related to intestinal ileus. Interview with the House Manager on October 9, 2007 at approximately 1:45PM revealed that this unusual incident was forwarded to the DOH. The DOH received notification of this incident on June 16, 2007.	1379	3519.10  The IMC did not receive the two incident reports cited within the first 24 hours after the incidents occurred and therefore did not and could not turn them around for DOH within 24 hours. The residential director will insure that staff in this home is re-trained on insuring that incident reports are submitted to the IMC within 24 hours of the event's occurrence... 11-15-07.		
1390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS  Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current "Outcome Performance Measures" from the "	1390			

Health Regulation Administration  
STATE FORM

6899

8ZZD11

If continuation sheet 4 of 7

PRINTED: 10/31/2007  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/10/2007
NAME OF PROVIDER OR SUPPLIER  M T S			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 TEWKESBURY PL, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1390	<p>Continued From page 4</p> <p>Council on Quality and Leadership in Support for People With Disabilities " (Council) and to the extent of funds appropriated for purposes of D.C. Law 2-137, as amended.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services included both diagnosis, evaluation, treatment and services designed to prevent deterioration or further loss of function for three of the three residents in the sample. (Residents #1, #2 and #3).</p> <p>The findings include:</p> <p>1. Interview and record review on October 9, 2007 at approximately 2:15 PM revealed that on October 1, 2007, the Qualified Mental Retardation Professional (QMRP) requested Medicaid Waiver Services for an annual speech assessment for Resident #1. Review of Resident #1's court documents dated January 6, 2006 on October 9, 2007, at approximately 2:20 PM, revealed a court recommendation that Resident #1 receive a Speech Assessment to develop formal language and writing programs to assist the resident with career goals. There was no documented evidence that Resident #1 was provided a speech assessment as recommended.</p> <p>2. Interview and record review on October 9, 2007 at approximately 2:30 PM revealed that on October 1, 2007, the QMRP requested Medicaid Waiver Services for annual speech assessments for Resident #2 and Resident #3. There was no documented evidence that Resident #2 and Resident #3 were provided speech assessments as recommended.</p>	1390			

Health Regulation Administration  
STATE FORM

6858

8ZZD11

If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/10/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 TEWKESBURY PL, NW WASHINGTON, DC 20012</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 390	Continued From page 5  3. Review of Resident #2's medical assessment dated February 2007 on October 10, 2007 at approximately 2:00PM revealed that the Primary Care Physician (PCP) recommended that Resident #2 have a chest x-ray for evaluation of his cough. Interview with the Registered Nurse on October 10, 2007 at approximately 2:10PM revealed that Resident #2 had a chest x-ray performed for evaluation of his cough, however she acknowledged that the results of the chest x-ray was not in the resident's records. There was no documented evidence that Resident #2 had a chest x-ray performed as recommended by the PCP.	I 390	3520.1  Residents #1, #2 and #3 will have speech assessments completed by....11-20-07. The QMRP will follow up to insure these assessments are successfully completed. The QMRP will systematically track all ISP assessment recommendations accepted by the team to insure they are implemented as prescribed....11-1-07.  MTS will obtain a copy of resident #2's chest x-ray by 11-7-07. But were told verbally there was no active disease. MTS will insure via tracking by nursing that consultation results are obtained, reviewed and acted upon in a timely manner...11-1-07.		
I 500	<b>3523.1 RESIDENT'S RIGHTS</b>  Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of three Residents included in the sample. (Resident #2 )  The finding includes:  Observation of the evening medication administration on October 9, 2007 at approximately 7:20 PM, revealed Resident #2 received Risperdal 2mg every evening by mouth,	I 500			

Health Regulation Administration  
STATE FORM

5699

8ZZD11

If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/10/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 TEWKESBURY PL, NW WASHINGTON, DC 20012</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 500	Continued From page 6  Diazepam 5 mg twice a day, Depakote 1000 mg twice a day by mouth and Keppra 75 mg twice a day by mouth. Interview with the Licensed Practical Nurse (LPN) and review of the physician's orders dated September 1, 2007 on October 9, 2007 at approximately 7:20 PM revealed that the medications were prescribed for behavior management and seizure management. Further interview with the LPN revealed that the medications were incorporated into Resident #2's Behavior Support Plan (BSP) dated March 15, 2007 to address maladaptive behaviors of physical aggression, verbal aggression, property destruction and loud vocalizations. Review of Resident #2's psychology assessment dated May 1, 2007, on October 10, 2007 at approximately 12:15 PM revealed that the resident does not evidence the capacity to make competent independent decisions. There was no documented evidence that the facility informed Resident #2 of the health benefits and risks of treatment associated with the use of his medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	I 500	3523.1  MTS is in the process of following up with the DDS case manager for resident #2 to insure that he has a decision making support person (guardian) to help with decisions like the one described. A guardian will be obtained by... 11-30-07. Once the guardian is in place, the drug regimen and BSP will be reviewed with the guardian and resident #2 to insure that informed consent is obtained... 12-15-07.		

Health Regulation Administration  
STATE FORM

6899

8ZZD11

If continuation sheet 7 of 7



Multi-Therapeutic Services, Inc. 4201 Connecticut Avenue, NW, Suite #405, Washington, DC 20008 FAX  
NO.: (202) 244-8048 PHONE NO.: (202) 244-4500

FACSIMILE TRANSMITTAL SHEET

TO: <i>Shaila Pinnel</i>	FROM: <i>John Green</i>
COMPANY: <i>DOH / HRA</i>	DATE: <i>11/2/07</i>
FAX NUMBER: <i>202-442-9430</i>	TOTAL NO. OF PAGES INCLUDING COVER: <i>8 pages</i>
PHONE NUMBER: <i>202</i>	SENDER'S REFERENCE NUMBER:
RE: <i>Newbury POC</i>	YOUR REFERENCE NUMBER:

☐ URGENT ☒ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

*Please see attached.*

STATEMENT OF CONFIDENTIALITY:

The information contained in this electronic message and any attachments to this message are intended for the exclusive use of the addressee(s) and may contain confidential or privileged information. If you are not the intended recipient, please notify the sender whose name appears above immediately at either (202) 244-4500 or e-mail at [MtsOrg@aol.com](mailto:MtsOrg@aol.com), then destroy all copies of this message and any attachments

Health Care Management: ICF/MR Development: Consulting